MIRECC Mental Illness Research, Education and Clinical Center

MINDVIEW

Improving the Quality of Life for Veterans with Psychosis

Volume 2, Issue 2 **May 2009**

Suicide Prevention

Damisi Graham, LCSW and Noosha Niv, Ph.D.

Suicide is the 11th leading cause of death in the United States. Approximately one person dies from suicide every 16.6 minutes, and male veterans are twice as likely as their male civilian counterparts to commit suicide. Increasing suicide prevention is a key element of the New Freedom Commission on Mental Health final report and the VHA Mental Health Strategic Plan. Senate hearings in April 2007 emphasized the importance of the VA making efforts to reduce veteran suicide and resulted in passing of the Joshua Omvig Veterans Suicide Prevention Act (H.R. 327) which was signed into law on November 5, 2007. The bill is named for Joshua Omvig, who suffered from post-traumatic stress disorder following an 11-month tour of duty in Iraq and completed suicide in December 2005 (www.joshua-omvig.memory-of.com).

The VA initiated an overall strategic plan to enhance mental health programs throughout the VA system to include both public health and clinical models of suicide prevention and intervention. The strategic plan includes targeted funding for specific Mental Health Initiatives, performance measures, and education for veterans, their families and the community. Additionally, JCAHO National Patient Safety Goal called for facilities to mitigate the risks of suicide through appropriate screening and action, including completion of Suicide Risk Assessments for any patient with a primary diagnosis or complaint of an emotional or behavioral disorder. As a result, VA funding was approved to hire one full time Suicide Prevention Coordinator at each facility nationally.

"The VA initiated an overall strategic plan to enhance mental health programs throughout the VA system to include both public health and clinical models of suicide prevention and intervention."

To date, there are 153 Suicide Prevention Coordinators, with at least one assigned to every VA Medical Center. The

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In This Issue:

Upcoming Events

~Social Skills Training

June 4-5, 2009

Location: Santa Monica, CA

Contact: Matt Wiley at (410) 605-7457 or matthew.wiley@va.gov

~Multi-Family Groups for Severe Mental Illness

June 22-25, 2009

Location: Long Beach, CA

Contact: Shirley Glynn at (310) 268-3163 or sglynn@ucla.edu

~3rd Annual VA Mental Health Conference

July 21-23, 2009

Location: Washington DC

Letter From The Director

Stephen R. Marder, MD

Suicide Among Veterans

Reports of suicides among returning veterans from Iraq and Afghanistan have reminded us that this is one of the most preventable causes of death. Unfortunately, suicide is very common. More individuals in the US die from suicide than homicide, and veterans have a substantially higher risk than the population at large. In addition, the conflicts in the Middle East are only one of a number of risk factors for suicide.

This issue of MindView focuses on new VA programs for suicide prevention. A VA Suicide Prevention Lifeline (1-800-273-TALK) is now active 24/7. More than 111,000 calls have been made to the hotline, and the hotline staff have initiated a number of rescues of veterans. In addition, every VA Medical Center has been authorized to hire a suicide prevention coordinator who will coordinate prevention activities and assist in educating staff about suicide prevention. Also, the MIRECC in the VA Rocky Mountain Network (VISN 19) has an ambitious research program that includes studies of the effectiveness of interventions for preventing suicide and studies of the neurobiology of factors that increase the risk of suicide.

The risk of suicide exists throughout the lifespan. Although individuals with depression and PTSD should be screened carefully for suicide, populations with substance abuse, serious medical illnesses, and others are also at risk. As noted in the article by Damisi Graham and Dr. Noosha Niv, individuals with schizophrenia also have a higher risk of suicide than those in the general population. In schizophrenia, symptoms such as command hallucinations, tormenting delusions, and feelings of hopelessness should alert clinicians to a possible risk of suicide.

New Directions Treats OEF/OIF Vets in its Co-Occurring Disorders Program

Monica Martocci, M.A., L.M.F.T., Clinical Director, New Directions, Inc.

New Directions, Inc. (NDI) integrates the treatment of chemical dependency and mental health issues in its Co-Occurring Disorders Program operating at the Greater Los Angeles VA campus. All NDI programs are zero tolerance, long-term, residential treatment and recovery programs, which incorporate the 12 steps of AA. Specialized clinical attention (each veteran has his own clinician), close coordination with the VA PTSD Clinic, and easy access to the array of medical and psychiatric care available from the VA Medical Center all combine to provide holistic support. Women veterans, including a handful who served in Iraq or Afghanistan, are treated in two private homes in the community.

New Directions has found that virtually all men returning from Iraq or Afghanistan are best served in the Co-Occurring Disorders Programs. Treatment in the Co-Occurring Disorders Program at New Directions is personalized to meet individual needs. A multidisciplinary team of psychiatrists, psychologists, social workers, addiction therapists, counselors, case managers, and employment specialists work cooperatively and consistently with total dedication to the needs of each client. By focusing on the origins of each individual's disorders, staff members identify and address the core patterns that have caused continual return to self-destructive behaviors.

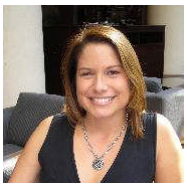
Aftercare, the crucial element in the continued success of recovery, begins with admission and is interwoven throughout treatment to provide a supportive, consistent transition from program to home or to Chris' Place, NDI's transitional home for OEF/OIF veterans in L.A. At Chris' Place, as many as six men live as a family while they train for specific jobs, seek higher education opportunities, and begin their job search in preparation for reintegration into the community.

At NDI, principles of care within mental health and addiction fields converge in respect for the individual, belief in the human capacity to change, and the importance of community, family, and peers in the recovery process.

New Directions, Inc. is a private, non-profit organization founded in 1992. For more information or to arrange a tour, contact Monica Martocci at (310) 268-3456 or by email mmartocci@NDVets.org.

Mental Health Recovery Plan

Stacey E. Maruska, LCSW



The Presidents New Freedom Commission was established in 2003 to address the fragmentation in the nation's mental health system and recommend improvements to enable adults with serious mental illnesses and children with serious emotional disturbances to live, work and participate fully in their communities. After conducting a comprehensive study of the U.S. mental health delivery system, the Commission recommended the following principles to transform our current mental health system: 1) mental health treatment and services should be consumer and family driven, geared to give consumers real and meaningful choices about treatment options and providers, and 2) care must focus on increasing consumers' ability to successfully cope with life's challenges, facilitating recovery, and building resilience, not just on managing symptoms.

Guidelines provided by the Accreditation Manual for Behavioral Healthcare state that treatment planning should be individualized and involve the client in the process. Treatment provider should relate their recommendations and concerns, and client should express their views and make choices about the plan of care, treatment or services. All interventions should consider and respect the client's views, and the client's participation in developing his or her plan of care should be documented.

Recovery Plans document a vision for the future and an action plan to achieve that vision. They link treatment and services to desirable, meaningful, and personal goals and bring together the veteran, his/her primary clinician or case manager, and his/her network of professional and natural supporters.

VISN 22 Local Recovery Coordinators have recommended that Recovery Plans be implemented at each VA facility and Community Based Outpatient Clinics. If you have any questions about these plans or any other questions related to recovery, contact your Local Recovery Coordinator.

Elements of a Good Recovery Plan

1) Basic biographical information about the veteran
2) Treatment team members names and review dates for plan
3) What the Veteran wants the treatment team to know about him/her
4) "Satisfaction with Areas of My Life"
5) Veteran's self-identified strengths, needs, and life goals
6) Obstacles to listed life roles and goals
7) Acknowledgement that Veteran participated and agrees with his recovery plan

Federal Government Seeks Public Comment on Implementation of the Mental Health Parity and Addiction Equity Act

Noosha Niv, Ph.D.

Buried within the Emergency Economic Stabilization Act, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act was signed into law by President Bush on October 3, 2008. Although the law does not mandate health insurance plans to offer mental health or substance use disorder benefits, it does require insurance plans that do offer such coverage to do so in parity with medical benefits. For example, it requires equity in treatment limits (i.e., number of visits and duration of coverage), financial requirements (i.e., deductibles, co-payments and out-of-pocket expenses) and out-of network coverage.

The Department of Health and Human Services, the Department of Labor and the Internal Revenue Service are the three federal government agencies principally responsible for implementing this law. These three agencies are currently seeking information and advice from the public addressing critical issues surrounding the best ways to implement the law and fulfill its objectives. To learn more about the law and/or to submit your comments, please visit http://edocket.access.gpo.gov/2009/pdf/E9-9629.pdf. Comments must be submitted by May 28, 2009.

National Suicide Hotline

Damisi Graham, LCSW

To ensure veterans with mental health crises have immediate access to trained mental health professionals, VA partnered with the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Suicide Prevention Lifeline to operate a national suicide prevention hotline for veterans. The toll-free hotline number is 1-800-273-TALK (8255). VA staff operates this hotline seven days a week, 24 hours a day at the Canandaigua VA Medical Center in New York State. Callers are prompted to press one if they are a veteran. The veteran is then immediately connected to trained staff at the Canandaigua VA who will care for the emergent need. The veteran will also be asked for consent allowing the local Suicide Prevention Coordinator to contact the veteran through a Suicide Hotline Consult. This consult assists in linking the caller with the appropriate mental health service and VA resources. Since the launch of the hotline in July 2007, the VA has received over 111,153 calls.

May is Mental Health Awareness Month Network Activities

Long Beach VA Medical Center

Mental Health Awareness Fair

Long Beach VA, Panteges Theatre
Thursday, May 14th from 10:30 am - 1:30 pm

- Community and VA informational booths
- Light refreshments

For more information contact: Stacey Maruska, LCSW (562) 826 -5274

Grand Rounds: NAMI Orange County Frontline

Long Beach VA, Building 128, Room C-202
Wednesday, May 27th from 12-1 pm
For more information contact: Stacey Maruska, LCSW (562) 826 -5274

Loma Linda VA Medical Center

Family-Vet Education: Bipolar Series

Loma Linda VA, Second floor, Room 2E37A
Tuesdays, 11:00-12:00
May 12: Overview
May 19: Medications
May 26: Community Resources
June 02: Consumers Share Recovery Stories
Please call (909) 825-7084, ext. 2862 to RSVP; Space is limited.
For more information contact: Clara Wise, OTR/L, CPRP
(909) 825-7084 ext. 2484

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Suicide Prevention

primary purpose of the Suicide Prevention Coordinators is to promote awareness at VA facilities about suicide, suicide risk factors, and suicide prevention, including promoting the belief that suicide prevention is everyone's responsibility. This includes facilitating Operation S.A.V.E. which trains non-clinicians at VA facilities and clinics to: 1) recognize SIGNS of suicidal thinking, 2) ASK veterans questions about suicidal thoughts, 3) VALIDATE the veteran's experience, and 4) ENCOURAGE the veteran to seek treatment. This also includes coordinating other training programs to provide ongoing education for all staff, such as Suicide Risk Management for Clinicians.

Suicide Prevention Coordinators assist VA facilities in identifying those veterans who may be at high risk for suicide and ensuring that these veterans receive the appropriate level of care and monitoring. The coordinators assist in identifying veterans who have previously attempted suicide and work with the Patients Safety Team to review the care that is provided to those veterans in order to determine areas for improvement in service delivery. In collaboration with the Patients Safety Team, Suicide Prevention Coordinators also monitor the environment in high risk areas of the hospital.

Suicide Prevention Coordinators are responsible for promoting veteran and community awareness of suicide prevention through educational and outreach efforts. National Suicide Awareness and Prevention Week is the first week in September annually, and VA Medical Centers have activities and educational information during that week, as well as throughout the year.

For more information about Suicide Awareness and Prevention Week, contact your local Suicide Prevention Coordinator.

Suicide in Schizophrenia: Did You Know?

⇒ Leading cause of premature deaths among persons with schizophrenia is suicide.

⇒ Individuals with schizophrenia are nine times more likely to die by suicide than the general population.

⇒ Up to 30% of people with schizophrenia attempt suicide and between 4% and 10% succeed.

⇒ Among individuals with schizophrenia, mild levels of suicidality should be identified and monitored as low-level suicidality predicts future suicidal thoughts and behaviors better than depression or anxiety.

VISN 22 - VA Lead Suicide Prevention Coordinators

Loma Linda	Long Beach	Southern Nevada	Greater Los Angeles	San Diego
Christine Lecei, LMSW	Damisi Graham, LCSW	Nick Clough, RN, MS, CS	Tana Teicheira, LCSW	Paula Saltz, LMSW
(909) 825-7084 x2715	(562) 826-8000 x4648	(702) 636-3000 x4666	(310) 478-3711 x43993	(858) 642-1439

Recent MIRECC Publications

Barch, D.M., Carter, C.S., Arnsten, A., Buchanan, R.W., Cohen, J.D., Geyer, M., et al. (2009). **Selecting paradigms from cognitive neuroscience for translation into use in clinical trials: Proceedings of the third CNTRICS meeting.** *Schizophrenia Bulletin, 35,* 109–114.

Brown, G.G., Delano-Wood, L., & Lazar, R. (2009). **Cerebrovascular disease.** In I. Grant & K. Adams. *Neuropsychological Assessment of Neuropsychiatric Disorders, 3rd Ed.*

Brown, G.G., McCarthy, G., Bischoff-Grethe, A., Ozyurt, B., Greve, D., et al. (2009). **Brain-performance correlates of working memory retrieval in schizophrenia: a cognitive modeling approach**. *Schizophrenia Bulletin, 35*, 32-46.

Eyler, L.T. & Brown, G.G. (In press). **Geriatric Psychiatry: Neuroimaging.** In B. J. Sadock, V. A. Sadock. *Comprehensive Textbook of Psychiatry (9th Ed.)*. Philadelphia: Lippincott Williams & Wilkins.

Ford, J.M., Roach, B.J., Jorgensen, K.W., Turner, J.A., Brown, G.G., et al. (2009). **Tuning in to the voices: a multisite FMRI study of auditory hallucinations.** *Schizophrenia Bulletin, 35*, 58-66.

Green, M.F., Butler, P.D., Chen, Y., Geyer, M.A., Silverstein, S., et al. (2009). **Perception measurement in clinical trials of schizophrenia: Promising paradigms from CNTRICS.** *Schizophrenia Bulletin, 35,*163–181.

Halberstadt, A.L., van der Heijden, I., Ruderman, M.A., Risbrough, V.B., Gingrich, J.A., Geyer, M.A., et al. (2009). **5-HT2A and 5-HT2C receptors exert opposing effects on locomotor activity in mice.** *Neuropsychopharmacology*, advanced online publication.

Horan, W.P., Kern, R.S., Sergi, M.J., Shokat-Fadai, K., Wynn, J.K., & Green, M.F. (2009). **Social cognitive skills training in schizophrenia: An initial efficacy study of stabilized outpatients.** *Schizophrenia Research, 107*, 47-55.

Horan, W.P., Nuechterlein, K.H., Wynn, J.K., Lee, J., Castelli, F., & Green, M.F. (2009). **Disturbances in the spontaneous attribution of social meaning in schizophrenia.** *Psychological Medicine, 39*, 635-644.

Hunter, S.B., Chinman, M., Ebener, P., Imm. P., Wandersman, A., & Ryan, G. (In press). **Technical assistance as a prevention capacity-building tool: A demonstration using the Getting To Outcomes framework.** *Health Education and Behavior.*

Hunter, S., Paddock, S., Ebener, P., Burkhart, Q., & Chinman, M. (In press). **Promoting evidence based practices: The adoption of a Prevention Support System in community settings.** *The Journal of Community Psychology.*

Kern, R.S., Green, M.F., Fiske, A.P., Kee, K.S., Lee, J., et al. (2009). **Theory of mind deficits for processing counterfactual information in persons with chronic schizophrenia.** *Psychological Medicine, 39*, 645-654.

Kim, D., Andreasen, N., Belger, A., Bockholt, J., Brown, G., et al. (In press). **Dysregulation of working memory and default-mode networks in schizophrenia during a Sternberg item recognition paradigm.** *Human Brain Mapping.*

Kim, D.I., Mathalon, D.H., Ford, J.M., Mannell, M., Turner, J.A., Brown, G.G., et al. (2009). **Auditory oddball deficits in schizophrenia: An independent component analysis of the fMRI multisite function BIRN study.** *Schizophrenia Bulletin, 35*, 67-81.

Mueser, K.T., Glynn, S.M., Cather, C., Zarate, R., Fox, L., et al. (In press). **Family intervention for co-occurring substance use and severe psychiatric disorder: Participant characteristics and correlates of initial engagement and more extended exposure in a randomized controlled trial.** *Addictive Behaviors.*

Nasrallah, H.A., Keshavan, M.S., Benes, F.M., Braff, D.L., Green, A.I., et al. (2009). **Proceedings and data from the schizophrenia summit: A critical appraisal to improve the management of schizophrenia.** *Journal of Clinical Psychiatry, 70 (Suppl 1),* 44-46.

Perry, W., Minassian, A., Paulus, M.P., Young, J.W., Kincaid, M., et al. (In press). **From Mice to Men: Neurobiology of dysfunctional exploration in psychiatric disorders.** *Archives of General Psychiatry.*

Potkin, S.G., Turner, J.A., Brown, G.G., McCarthy, G., Greve, D.N., et al. (2009). **Working memory and DLPFC inefficiency in schizophrenia: The FBIRN study.** *Schizophrenia Bulletin, 35,* 19-31.

Sergi, M.J., Fiske, A.P., Horan, W.P., Kern, R.S., Nuechterlein, K.H., & Green, M.F. (2009). **Relationships across domains: A new measure of relationship perception in schizophrenia.** *Psychiatry Research, 166*, 54-62.

Wible, C.G., Lee, K., Molina, I., Hashimoto, R., Preus, A.P., et al. (2009). **fMRI activity correlated with auditory hallucinations during performance of a working memory task: Data from the FBIRN consortium study.** *Schizophrenia Bulletin, 35*, 47-57.

Young, J.W., Light, G.A., Marston, H.M., Sharp, R., & Geyer, M.A. (2009). **The 5-choice continuous performance test: Evidence for a translational test of vigilance test for mice.** *PLoS ONE, 4*, e4227.

Young, J.W., Powell, S.B., Risbrough, V.B., Marston, H.M., & Geyer, M.A. (In press). **Using the MATRICS to guide development of a preclinical cognitive test battery for research in schizophrenia.** *Pharmacology and Therapeutics.*

Zhou, X. Tang, W., Greenwood, T.A., Guo, S., He, L., Geyer, M.A., et al. (2009). **Transcription factor SP4 is a susceptibility gene for bipolar disorder.** *PLoS ONE*, 4, e5196.

New Grants

"Pathway(s) From Genes to Functional Deficits of Schizophrenia Patients"
Principal Investigator: Gregory Light, Ph.D.
Funded by the National Institute of Mental Health

Awards

Congratulations to Dr. David Braff for being named the 2009 President of the American College of Neuropsychopharmacology (ACNP). Dr. Braff was also presented with the William K. Warren Award from the International Congress on Schizophrenia Research on April 1, 2009.

Mental Illness Research, Education and Clinical Center

VA Desert Pacific Healthcare Network

Long Beach VA Healthcare System

Education and Dissemination Unit 06/116A

5901 E. 7th Street

Long Beach, CA 90822

Director

Stephen R. Marder, MD

Director, Education and Dissemination Unit

Christopher Reist, MD

MindView Editor
Associate Director, Education and Dissemination Unit

Noosha Niv, Ph.D.

Contributors

Damisi Graham, LCSW

Monica Martocci, M.A., L.M.F.T.

Stacey Maruska, LCSW

MindView Questions or Comments

Contact Noosha Niv at noosha.niv@va.gov

VISIT US ON THE INTERNET AT:

www.desertpacific.mirecc.va.gov

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